| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-125388894* | *State:* | *Arkansas* |
| *Filing Company:* | *American Modern Home Insurance Company* | *State Tracking Number:* | *50* |
| *Company Tracking Number:* | *AMH-7000 (08-07)* | | |
| *TOI:* | *33.0 Other Lines of Business* | *Sub-TOI:* | *33.0001 Other Personal Lines* |
| *Product Name:* | *American Modern Home Insurance Company* | | |
| *Project Name/Number:* | *AMHI-7000/AMHI-7000 (08-07)* | | |

## Filing at a Glance

Company: American Modern Home Insurance Company

| | | |
|---|---|---|
| Product Name: American Modern Home Insurance Company | SERFF Tr Num: ICCI-125388894 | State: Arkansas |
| TOI: 33.0 Other Lines of Business | SERFF Status: Closed | State Tr Num: 50 |
| Sub-TOI: 33.0001 Other Personal Lines | Co Tr Num: AMH-7000 (08-07) | State Status: Fees verified |
| Filing Type: Form | Co Status: | Reviewer(s): Betty Montesi, Edith Roberts, Brittany Yielding |
| | Author: Brenda Dawson | Disposition Date: 12/27/2007 |
| | Date Submitted: 12/14/2007 | Disposition Status: Approved |
| Effective Date Requested (New): On Approval | | Effective Date (New): |
| Effective Date Requested (Renewal): | | Effective Date (Renewal): |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: AMHI-7000 | Status of Filing in Domicile: Pending |
| Project Number: AMHI-7000 (08-07) | Domicile Status Comments: |
| Reference Organization: | Reference Number: AMH-7000 (08-07) |
| Reference Title: AMH-7000 | Advisory Org. Circular: |
| Filing Status Changed: 12/27/2007 | |
| State Status Changed: 12/27/2007 | Deemer Date: |
| Corresponding Filing Tracking Number: | |

Filing Description:

Group Involuntary Unemployment form filing

## Company and Contact

**Filing Contact Information**

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Brenda Dawson, Authorized Representative Brendadawson@inscompliance.com

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-125388894* | *State:* | *Arkansas* |
| *Filing Company:* | *American Modern Home Insurance Company* | *State Tracking Number:* | *50* |
| *Company Tracking Number:* | *AMH-7000 (08-07)* | | |
| *TOI:* | *33.0 Other Lines of Business* | *Sub-TOI:* | *33.0001 Other Personal Lines* |
| *Product Name:* | *American Modern Home Insurance Company* | | |
| *Project Name/Number:* | *AMHI-7000/AMHI-7000 (08-07)* | | |

519 Colman Center Drive
Rockford, IL 61108

(815) 316-6714 [Phone]
(815) 316-6720[FAX]

**Filing Company Information**

American Modern Home Insurance Company
P. O. Box 5323
Cincinnati, OH 45021
(800) 890-6980 ext. [Phone]

CoCode: 23469
Group Code:
Group Name:
FEIN Number: 31-0715697

State of Domicile: Ohio
Company Type:
State ID Number:

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|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-125388894* | *State:* | *Arkansas* |
| *Filing Company:* | *American Modern Home Insurance Company* | *State Tracking Number:* | *50* |
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| *TOI:* | *33.0 Other Lines of Business* | *Sub-TOI:* | *33.0001 Other Personal Lines* |
| *Product Name:* | *American Modern Home Insurance Company* | | |
| *Project Name/Number:* | *AMHI-7000/AMHI-7000 (08-07)* | | |

# Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $50.00 |
| Retaliatory? | No |
| Fee Explanation: | |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| American Modern Home Insurance Company | $50.00 | 12/14/2007 | |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-125388894* | *State:* | *Arkansas* |
| *Filing Company:* | *American Modern Home Insurance Company* | *State Tracking Number:* | *50* |
| *Company Tracking Number:* | *AMH-7000 (08-07)* | | |
| *TOI:* | *33.0 Other Lines of Business* | *Sub-TOI:* | *33.0001 Other Personal Lines* |
| *Product Name:* | *American Modern Home Insurance Company* | | |
| *Project Name/Number:* | *AMHI-7000/AMHI-7000 (08-07)* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved | Edith Roberts | 12/27/2007 | 12/27/2007 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-125388894* | *State:* | *Arkansas* |
| *Filing Company:* | *American Modern Home Insurance Company* | *State Tracking Number:* | *50* |
| *Company Tracking Number:* | *AMH-7000 (08-07)* | | |
| *TOI:* | *33.0 Other Lines of Business* | *Sub-TOI:* | *33.0001 Other Personal Lines* |
| *Product Name:* | *American Modern Home Insurance Company* | | |
| *Project Name/Number:* | *AMHI-7000/AMHI-7000 (08-07)* | | |

# Disposition

Disposition Date: 12/27/2007
Effective Date (New):
Effective Date (Renewal):
Status: Approved
Comment:
Approval is based on receipt of fees.  Please submit in order to avoid rescinsion of approval.  Thanks.

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-125388894* | *State:* | *Arkansas* |
| *Filing Company:* | *American Modern Home Insurance Company* | *State Tracking Number:* | *50* |
| *Company Tracking Number:* | *AMH-7000 (08-07)* | | |
| *TOI:* | *33.0 Other Lines of Business* | *Sub-TOI:* | *33.0001 Other Personal Lines* |
| *Product Name:* | *American Modern Home Insurance Company* | | |
| *Project Name/Number:* | *AMHI-7000/AMHI-7000 (08-07)* | | |

| Item Type | Item Name | Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Uniform Transmittal Document-Property & Casualty | | Yes |
| **Supporting Document** | AMHI Authorization Letter | | Yes |
| **Supporting Document** | Cover letter | | Yes |
| **Supporting Document** | Readability Certification | | Yes |
| **Supporting Document** | Fee schedule | | Yes |
| **Supporting Document** | Certification of Compliance | | Yes |
| **Form** | Group Application | | Yes |
| **Form** | Group Policy | | Yes |
| **Form** | Family Leave Rider | | Yes |
| **Form** | Hospitalization Rider | | Yes |
| **Form** | Joint Coverage Rider | | Yes |
| **Form** | Medical Withdrawal Rider | | Yes |
| **Form** | Accidental Death Rider | | Yes |
| **Form** | Enrollment Application | | Yes |
| **Form** | Change Form | | Yes |
| **Form** | Group Certificate | | Yes |
| **Form** | Accidental Disability Rider | | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-125388894* | *State:* | *Arkansas* |
| *Filing Company:* | *American Modern Home Insurance Company* | *State Tracking Number:* | *50* |
| *Company Tracking Number:* | *AMH-7000 (08-07)* | | |
| *TOI:* | *33.0 Other Lines of Business* | *Sub-TOI:* | *33.0001 Other Personal Lines* |
| *Product Name:* | *American Modern Home Insurance Company* | | |
| *Project Name/Number:* | *AMHI-7000/AMHI-7000 (08-07)* | | |

# Form Schedule

| Review Status | Form Name | Form # | Edition Date | Form Type | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|---|
| | Group Application | AMH-7000-15 (08-07) | 12/10/07 | Application/ Binder/Enrollment | New | | 51.08 | AMH-7000-15GroupPolicyholderApplication.pdf |
| | Group Policy | AMH-7000-25 (08-07) | 12/10/07 | Policy/Coverage Form | New | | 51.08 | AMH-7000-25GroupPolicy.pdf |
| | Family Leave Rider | AMH-7000-51 (08-07) | 12/10/07 | Endorsement/Amendment/Conditions | New | | 51.08 | AMH-7000-51FamilyLeaveRider.pdf |
| | Hospitalization Rider | AMH-7000-52 (08-07) | 12/10/07 | Endorsement/Amendment/Conditions | New | | 51.08 | AMH-7000-52HospitalizationRider.pdf |
| | Joint Coverage Rider | AMH-7000-54 (08-07) | 12/10/07 | Endorsement/Amendment/Conditions | New | | 51.08 | AMH-7000-54JointCoverageRider.pdf |
| | Medical Withdrawal Rider | AMH-7000-55 (08-07) | 12/10/07 | Endorsement/Amendment/Conditions | New | | 51.08 | AMH-7000-55MedicalWithdrawalRider.pdf |
| | Accidental Death Rider | AMH-7000-70 (08-07) | 12/10/07 | Endorsement/Amendment/Conditions | New | | 51.08 | AMH-7000-70ADRider.pdf |
| | Enrollment Application | AMH-7000-40 (08-07) | 12/10/07 | Application/ Binder/Enrollment | New | | 51.08 | AMH-7000-40EnrollmentForm.pdf |
| | Change Form | AMH-7000-50 (08-07) | 12/10/07 | Application/ Binder/Enrollment | New | | 51.08 | AMH-7000-50ChangeRequestForm. |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-125388894* | *State:* | *Arkansas* |
| *Filing Company:* | *American Modern Home Insurance Company* | *State Tracking Number:* | *50* |
| *Company Tracking Number:* | *AMH-7000 (08-07)* | | |
| *TOI:* | *33.0 Other Lines of Business* | *Sub-TOI:* | *33.0001 Other Personal Lines* |
| *Product Name:* | *American Modern Home Insurance Company* | | |
| *Project Name/Number:* | *AMHI-7000/AMHI-7000 (08-07)* | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | pdf |
| Group Certificate | AMH-7000-35 (08-07) | 12/10/07 | Certificate | New | | 51.08 | AMH-7000-35Certificate.pdf |
| Accidental Disability Rider | AMH-7000-80 (08-07) | 12/10/07 | Endorsement/Amendment/Conditions | New | | 51.08 | AMH-7000-80DisabilityRider.pdf |

# American Modern Home Insurance Company
## Home Office: Amelia, Ohio
**[Administrative Office: 100 W. Bay Street, Jacksonville, FL 32202]**

### APPLICATION FOR GROUP INVOLUNTARY UNEMPLOYMENT INSURANCE

The Applicant named below hereby makes application for Group Policy Form [ 123456 ] [The Group Policy is to be effective in [Arkansas] and governed by the laws thereof.]

Insurance is provided under the Group Policy for Covered Persons included in Applicant's group who are eligible under the terms and conditions of the Group Policy.

Coverages offered to Covered Persons in the Group may include Involuntary Unemployment and may include riders for Accidental Death, Disability, Accidental Disability, Family Leave, Hospitalization, Medical Withdrawal, and/or Joint Coverage. Benefits will be determined according to the provisions of the Group Policy.

Coverages are subject to eligibility requirements, dollar limits, time restrictions, conditions and exclusions for each Coverage as defined in the Group Policy and Certificates of Insurance.

It is desired that the Policy shall become effective at 12:01 a.m. at the Group Policyholder's address on the [ 1st ] day of [ October ], [ 2007 ]

Dated this [ 1st ] day of [ October ], [ 2007 ].

Group Policyholder: [ABC Policyholder Association]
Group Policyholder Address: [1234 Nowhere Street]
[Anytown, Arkansas 111111]

By: [I.B. Director, Executive Vice President]
(Name and Title)

Accepted By: **AMERICAN MODERN HOME INSURANCE COMPANY**

By: [Frank May, Senior Vice President]
(Name and Title)

## SPECIFIC STATE NOTICES

**Fraud Warning:**

If You reside in, or are applying for, insurance under a policy issued in one of the following states, please read the applicable warning.

**Alaska Residents:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arizona Residents:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas and New Mexico Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**California Residents:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Delaware and Idaho Residents:** Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of a claim containing any false, incomplete, or misleading information is guilty of a felony.

**District of Columbia Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Hawaii Residents:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Indiana Residents:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Louisiana Residents and any state not listed:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Tennessee and Virginia Residents**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

**Maine Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Minnesota Residents:** A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire Residents:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in R.S.A. §638:20.

**New Jersey Residents:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

**Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or application containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact may be guilty of an insurance fraud, which is a crime, and may be subject to prosecution.

**Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Texas and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

# American Modern Home Insurance Company

**Home Office: Amelia, Ohio**
**[Administrative Office: 100 W. Bay Street, Jacksonville, FL 32202]**

## GROUP INVOLUNTARY UNEMPLOYMENT INSURANCE POLICY

This Group Involuntary Unemployment Insurance Policy (herein referred to as "this Policy") is issued to the Group Policyholder named on the Policy Schedule of Insurance. We are issuing this Policy in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits In accordance with all the provisions of this Policy.

Premiums are payable to Us or Our agent in amounts determined by this Policy. Premiums are due as provided by the provisions of this Policy.

## EFFECTIVE DATE; RENEWAL AGREEMENT

**EFFECTIVE DATE**. This Policy and the insurance provided by it become effective 12:01 A.M. at the Group Policyholder's address on the Effective Date shown on the Policy Schedule of Insurance.

**RIGHT TO RENEW**. This Policy is renewable at Our option subject to the payment of premiums when due. The Covered Person may renew his insurance subject to the Individual Termination of Insurance Provision.

[ Secretary President ]

GROUP INVOLUNTARY UNEMPLOYMENT INSURANCE POLICY

**CONTENTS**

## POLICY SCHEDULE OF INSURANCE

Group Policy Number: [ 123456 ]
Effective Date: [ 10-01-2007 ]

Group Policyholder: [ ABC Policyholder Association]

Insurance Benefits are determined by all provisions of this Policy including but not limited to all eligibility requirements, dollar limits, time limits, definitions and exclusions. Coverages offered to Covered Persons in the Group include Involuntary Unemployment and may include riders for Family Leave, Hospitalization, Medical Withdrawal, and/or Joint Coverage. Specific Benefit Amounts and Time Periods for each Covered Person and coverage offered will be stated on the Certificate Schedule of Insurance provided to the Covered Person.

## DEFINITIONS

When used in this Policy the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

**BENEFIT PERIOD** means the period of consecutive days of Loss for which a benefit is payable. Benefits will begin on the 1st day of the Loss after the [Vesting Period and] Elimination Period [have] [has] been satisfied. The Benefit Period will stop on the earliest of: 1) the date the Covered Person is no longer incurring the Loss; or 2) when benefits are paid for the Maximum Benefit Period shown on the Certificate Schedule of Insurance; or 3) when the Maximum Aggregate Benefit Amount has been paid as shown on the Certificate Schedule of Insurance. The same continuous Loss is not eligible for more than one Benefit Period.

**COVERED PERSON** (herein called “He,” “His” or “Him”) means the Covered Person named on the Certificate Schedule of Insurance.

**[DECLARED EXPENSE** means the monthly expense or expenses listed on the Certificate Schedule of Insurance which are used to determine the Monthly Benefit Amount.]

**[DESIGNATED PAYEE** means the payee for the Declared Expense(s) as provided by the Covered Person in the Proof of Loss form for a given claim as confirmed by Us. The Designated Payee will serve as payee for Benefits on behalf of the Covered Person. We will not be obligated to pay any amounts under this Policy to a Covered Person, Covered Person’s beneficiary or any other person, whether as loss payee, third party beneficiary, or other claimant, other than the confirmed Designated Payee.]

**[ELIMINATION PERIOD** means a period of consecutive [days/months] of Loss for which no benefit is payable. The Elimination Period is shown on the Certificate Schedule of Insurance and begins on the first day of the Loss. Benefits are payable beginning on the first day after the Elimination Period is satisfied. The Elimination Period will not begin until the Vesting Period, if any, has been satisfied and the Covered Person is eligible for Benefits.]

**EMPLOYMENT** means working full time for salary or wages at least [30 hours] per week.

**INVOLUNTARY UNEMPLOYMENT** means that the Covered Person has totally and continuously lost his full-time Employment as a result of:
(1) a permanent involuntary termination of employment; or
(2) an involuntary layoff or suspension of employment; or
(3) an authorized, unionized strike or labor dispute by a chartered or previously organized trade or labor union; or
(4) a lockout, discharge of employees or temporary closing of business in response to organized employee activity; or
(5) a state or federally declared disaster caused by a geological or weather-related natural event.

**GROUP POLICYHOLDER** means the legal entity in whose name this Policy is issued as shown on the Policy Schedule. The terms “You”, “Your” or “Yours” mean the Group Policyholder.

**LOSS** means an event of Involuntary Unemployment. [For additional Benefit Riders, Loss is defined as provided by those Riders.]

**[MAXIMUM AGGREGATE BENEFIT AMOUNT** means the dollar amount shown on the Certificate Schedule of Insurance under the "Maximum Aggregate Benefit Amount" Column per coverage. The sum of all Monthly Benefit Amounts per coverage paid under this Policy will not exceed the Maximum Aggregate Benefit Amount per coverage.]

**[MAXIMUM MONTHLY BENEFIT AMOUNT** means the dollar amount shown on the Certificate Schedule of Insurance under the "Maximum Monthly Benefit Amount" Column per coverage. The Monthly Benefit Amount will not exceed the Maximum Monthly Benefit Amount per month per coverage.]

**[MAXIMUM COVERAGE PERIOD** means the period of consecutive [days/months] during which a Covered Person is eligible to file a claim for Loss under this Policy. The Maximum Coverage Period begins on the Covered Person's Certificate Effective Date. The Maximum Coverage Period ends on the last day of the [XX] month from Certificate Effective Date. Benefits activated prior to the last day of the Maximum Coverage Period can continue until the Borrower's continuous Loss ceases, subject to the Maximum Monthly Benefit Amount and Maximum Benefit Period.]

**[MONTHLY BENEFIT AMOUNT** means [the dollar amount shown on the Certificate Schedule of Insurance under the "Monthly Benefit Amount" Column.] *[or*] [the amount owed by the Covered Person for the Declared Expense(s) listed on the Certificate Schedule of Insurance as of the last billing period preceding the date when the Loss begins.] The Monthly Benefit Amount, once determined for a given Loss, will remain constant throughout the Benefit Period for that Loss and may differ from the Covered Person's actual monthly expenses. The Monthly Benefit Amount is payable to the [Covered Person] [Designated Payee(s)] in the event of a Loss for the applicable Benefit Period, subject to the eligibility requirements, dollar limits, time restrictions, conditions and exclusions contained in the Policy.] [The Monthly Benefit Amount may not exceed the Maximum Monthly Benefit Amount per month or the Maximum Aggregate Benefit Amount per Covered Person shown on the Certificate Schedule of Insurance.]

**[NONCONTRIBUTORY PERIOD** means a period of consecutive [days/months] from the Effective Date of the Covered Person's Certificate during which the Group Policyholder provides coverage to the Covered Person [at no cost] [at a reduced cost] to the Covered Person. The Noncontributory Period for each Coverage is shown on the Certificate Schedule of Insurance. After the Noncontributory Period, the Covered Person may elect to renew coverage or change coverage by contacting Us and completing a change request form; however, the date the renewal or changes go into effect will be considered a new Certificate Effective Date for purposes of applying waiting periods and coverage exclusions.]

**POLICY** means the contract issued to the Group Policyholder providing the benefits described.

**[REQUALIFICATION PERIOD** means a period of consecutive [days/months] which must elapse between the end of one Benefit Period and the beginning of another Benefit Period before the Covered Person is eligible to file a new claim for Loss for the same type of coverage. The same continuous Loss is not eligible for more than one benefit period. The Requalification Period for each Coverage is shown on the Certificate Schedule of Insurance.]

**[VESTING PERIOD** means a period of consecutive [days/months] from the Effective Date of the Covered Person's Certificate during which the Covered Person is not eligible to file a claim or receive Benefits even if a Loss occurs. The Vesting Period, if any, for each Coverage is shown on the Certificate Schedule of Insurance of Insurance.]

**WE, US, AND OUR** means the insurer, American Modern Home Insurance Company.

## ELIGIBILITY OF COVERAGE

Each person age [18] through [70] who is included in the Group Policyholder's group is eligible to become a Covered Person. [**For Riders covering [Accidental Death], [Disability], [Accidental Disability], [Family Leave], [Hospitalization], and/or [Medical Withdrawal ], benefits will be reduced by [50%] if Loss occurs after attaining age [60] and will expire by age [71].]**

Covered Persons may qualify for benefits under only one Involuntary Unemployment Certificate under this Policy with Us. If any person is insured under more than one Certificate under this Policy, We will consider that person to be insured only under the Certificate which provides the greatest amount of coverage. Upon discovery of the duplication, We will cancel any duplicated coverages and refund premium payments which may have been made

on behalf of that person.

## BENEFITS

Benefits payable under this Policy are subject to all provisions of this Policy.

**INVOLUNTARY UNEMPLOYMENT BENEFIT:** We will pay a benefit if the eligible Covered Person files written Proof of Loss for His Involuntary Unemployment while this Policy is in effect and while He is within His Maximum Coverage Period. Benefits will begin on the 1st day of Involuntary Unemployment after the Vesting Period, if any, and Elimination Period have been satisfied. If, after the Elimination Period, the Covered Person's Involuntary Unemployment includes a period of less than a full month, We will pay 1/30th of the monthly benefit for each day of that period. The Covered Person will periodically be required to give Us written Proof of Loss of His continuing Involuntary Unemployment.

The Covered Person must register and be approved for Unemployment benefits with His state unemployment office. He also must be actively seeking Employment through a recognized Employment agency starting no later than 30 days after He loses His Employment. The Covered Person must continue to remain registered with the state unemployment office to continue to be eligible for benefits.

Payments will stop when the Covered Person is no longer Involuntarily Unemployed or when maximum time limits or dollar limits shown on the Certificate Schedule of Insurance are reached, whichever comes first.

Following the end of any previous claim for Involuntary Unemployment benefits, the Covered Person may file a new claim for Involuntary Unemployment benefits after he has been employed for wages or profit for at least [30 hours] per week for the duration of the Requalification Period shown on the Certificate Schedule of Insurance.

## EXCLUSIONS

No Benefits will be paid by Us under this Policy or the Certificates if the Covered Person:

[[1.] is Involuntarily Unemployed during the Vesting Period, if any, or Elimination Period;]
[[2.] voluntarily quits, resigns, retires or has an employment contract expire or is receiving severance pay;]
[[3.] dies or is on disability, on family leave or on sick leave due to an accident, sickness, childbirth or pregnancy;]
[[4.] is a temporary worker, a seasonal worker or an employee of an educational facility on a scheduled seasonal break;]
[[5.] is terminated as a result criminal misconduct as defined by local, state or federal law (including but not limited to use of illegal drugs);]
[[6.] is terminated as a result of willful misconduct meaning a transgression of some established rule of conduct, a forbidden act or a willful act of dishonesty or dereliction of duty;]
[[7.] is employed by a member of his immediate family including but not limited to a spouse, parent, child or sibling;]
[[8.] becomes aware either orally or in writing of pending unemployment within 90 days prior to the Effective Date of his Certificate;]
[[9.] is self-employed or an independent contractor;]
[[10.] becomes unemployed as a result of war, declared or undeclared, riot, insurrection, rebellion, or revolution;]
[[11.] becomes unemployed as a result of a discharge of pollutants or a nuclear occurrence;]
[[12.] has not been currently employed at a full time job and working at least thirty (30) hours per week for at least [6] consecutive [months] immediately prior to the date the Covered Person's Involuntary Unemployment begins;]
[[13.] is a sole proprietor, partner or a controlling stockholder in the business in which he is employed or is a dependent of a sole proprietor, partner or a controlling stockholder in the business in which he is employed;]
[[14.] is currently receiving benefits for any other Loss under this Policy or Certificate]

## INDIVIDUAL TERMINATION OF INSURANCE

The Covered Person's coverage under the Certificate automatically ends on the first of the following dates:

(1) The date this Policy is terminated; [or]
(2) The date the Maximum Coverage Period ends or the Maximum Aggregate Benefit is reached for all coverages;] [or]
(3) The premium due date the Covered Person [or Group Policyholder] fails to pay the required premium, except as provided in the Grace Period; [or]
[(4)The premium due date next following the date the Covered Person ceases to participate in the Group Policyholder's plan of Insurance under this Policy;][or]

[(5) The next [monthly] premium due date following attainment of age [71].] [or]
[(6) The date the Covered Person dies (only applicable to that Covered Person).

Termination of this Policy will not prejudice any claim originating prior to termination subject to all other terms of this Policy.

## PREMIUMS

**PAYMENT OF PREMIUM.** All premiums due by the terms of this Policy shall be paid to [Our Administrative Office] on or prior to the day they are due as stated on the Certificate Schedule of Insurance. The Covered Person is required to pay the premium shown on the Certificate Schedule of Insurance to keep this coverage in force.

**PREMIUM CHANGES.** We have the right to change the premium rates under this Policy by giving the Group Policyholder and the Covered Person at least 30 days advance written notice. Premium rates may also change at any time the Group Policyholder or Covered Person makes a coverage change request which We agree to accept.

**GRACE PERIOD.** If a premium is not paid when due, the insurance shall be in default. We will allow a [30 day] Grace Period to pay each premium after the first premium. If a premium is not paid at the end of the Grace Period, the insurance shall terminate as of the last date for which premiums were paid. When a Benefit is paid for a Loss incurred during the Grace Period, any premium due and unpaid may be deducted from the Benefit payment. The Covered Person's Certificate will lapse if the Covered Person does not pay his premium before the end of the Grace Period.

## CLAIMS PROVISIONS

**NOTICE OF CLAIM.** Written Notice of Claim must be given to Us within [30 days] after the date of Loss or as soon as possible but no later than one year] from the date of Loss, unless the Covered Person is legally incapable of doing so. The Notice should give the Covered Person's and Policyholder's name and the date of Policy enrollment. Notice should be mailed to [Our Administrative Office].

**CLAIM FORMS**. When We receive Notice of Claim, We will send the claimant forms for filing Proof of Loss within 15 business days. The Claim Form must be completed by the Covered Person and such other persons or officials as may be required in the Form. No claim will be approved or activated until the Claim Form is properly completed by all required parties and returned to Our Administrator. We must receive the completed Claim Form within the time given for filing Proof of Loss.

**PROOF OF LOSS**. For Involuntary Termination or Layoff, satisfactory written evidence that the Covered Person has registered for work with his state employment office or a recognized employment agency within 30 days after the last day employed and remains registered and actively seeking new employment while Benefits are activated. For a Strike or Lockout, satisfactory evidence of involuntary unemployment, which may include a statement signed by a union officer. The Covered Person must give satisfactory written proof of continuing Involuntary Unemployment on a monthly basis or any time upon Our request.

**TIME OF PAYMENT OF CLAIMS**. If it is determined benefits are payable, We Will pay all benefits covered by this Policy after We receive Proof of Loss satisfactory to Us.

**PAYMENT OF CLAIMS**. Benefits provided by this Policy will be paid after satisfactory Proof of Loss is received and We have determined We are liable.

[All Benefits are paid directly to the Covered Person, unless otherwise specified. If the Covered Person dies, the benefit will be payable to the Covered Person's Beneficiary, or, if there is no Beneficiary, to His estate.]
*[OR]*
[All Benefits are paid to the Designated Payee identified in the Claim Form for Proof of Loss. We will not be obligated to pay any amounts under this Policy to a Covered Person, Covered Person's beneficiary or any other person, whether as loss payee, third party beneficiary, or other claimant, other than the confirmed Designated Payee.]

## GENERAL PROVISIONS

**CONFORMITY TO LAW**. Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which it is issued is amended to conform to the laws of that state.

**ENTIRE CONTRACT.** This Policy, together with the Policyholder Application, Certificate and any other attachments including any Riders, make up the entire contract of Insurance. This Policy may be changed by written agreement between the Policyholder and Us. Only one of Our Officers may waive or otherwise change any provision of this Policy or Our rights hereunder, and no action, statement or agreement by any person or persons other than one of Our Officers in writing shall in any way bind or estop Us from enforcing the provisions of this Policy or Our rights hereunder. No agreement in conflict with, modifying or extending this Policy shall be valid unless in writing signed by one of Our Officers and made part of this Policy. An agent or broker cannot change or waive Policy provisions.

**CERTIFICATES.** We will provide Certificates to each Covered Person. The Certificates will describe the coverage provided, to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

Any conflict between terms of the Certificate and this Policy will be decided in favor of this Policy.

If the Covered Person is not satisfied for any reason, He may return His Certificate within [30 days] after receipt. Any premium paid will be refunded. When so returned, the Certificate will be void from the beginning. The Certificate must be returned to Us at Our Administrative Office.

**MISSTATEMENT OF AGE.** If, as a result of misstatement of age by the Covered Person, We accept a premium for any period when coverage would not normally have been in effect, then Our liability for such period shall be limited to a refund of all premiums paid for such period.

**MISREPRESENTATION, FRAUD AND OUR RIGHT TO RESCIND.** If We determine that the Covered Person has concealed or misrepresented his health, or any material fact in the application or proof of loss, attempted fraud, or false swearing and the coverage was issued or benefits paid in reliance upon those statements, We will deny the claim and, if applicable, rescind coverage. Our liability will be limited to the return of premiums, less benefits paid for such coverage

**NONPARTICIPATING.** This Policy is a non-participating policy; it does not share in Our surplus.

**RECORDS.** Sufficient records must be maintained by the Group Policyholder to show the names of all Covered Persons, the dates they became insured, and any such other information required to administer this Policy.

**RIGHT TO TERMINATE.** You or We may end this Policy by giving written notice to the other [30 days] prior to the desired date of termination. You must notify all Covered Persons of such Policy termination.

**RIGHT OF RECOVERY**. If payments for claims exceed the maximum amount payable under any benefit provisions [or riders] of this Policy, We have the right to recover the excess of such payments.

**LEGAL ACTIONS**. No action can be brought to recover on this Policy for at least [60 days] after written Proof of Loss has been furnished. No such action shall be brought more than [3 years] after the date Proof of Loss is required. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

**INCOME TAXATION.** Any benefits paid do not include provision for income tax owed by the Covered Person or his estate. The Covered Person should consult his own tax advisors regarding the tax consequences of any benefits received under this Policy.

# American Modern Home Insurance Company
## Home Office: Amelia, Ohio
**[Administrative Office: 100 W. Bay Street, Jacksonville, FL 32202]**

## FAMILY LEAVE RIDER

This Family Leave Rider is a part of the Policy/Certificate to which it is attached. It is issued in consideration of the application/enrollment form and the payment of the required premium.

For the purposes of this Rider, "Family Leave" means the Covered Person's employer-approved leave of absence from employment without pay to care for a newborn, a newly adopted child or an incapacitated family member (parent, child or spouse).

We will pay the Benefit Amount shown on the Schedule of Insurance if You file written Proof of Loss that You have been granted an unpaid, employer-approved leave of absence, while insured, and stating the reason for the leave of absence. If the Covered Person's Family Leave includes a period of less than a full month, We will pay 1/30$^{th}$ of the monthly Benefit Amount for each day of Family Leave. You will periodically be required to give Us written proof of the continuing Family Leave.

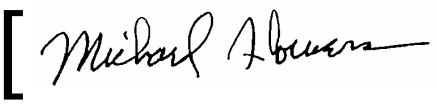
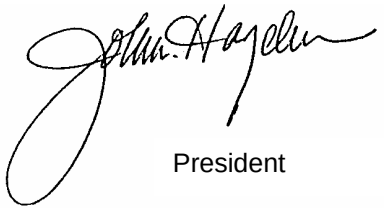
Payments will stop on the earliest of: 1) the date the Covered Person is no longer on Family Leave; or 2) when We have paid Benefits for the Maximum Benefit Period shown on the Schedule of Insurance.

**Exclusions:**
No Benefits will be paid by Us under the Policy or Certificate if You:

[[1.] have not satisfied either the Vesting Period or Elimination Period, if any;]
[[2.] voluntarily quit, resign, retire or have an employment contract expire;]
[[3.] die or are on disability or on sick leave due to Your own accident, sickness, childbirth or pregnancy;]
[[4.] are a temporary worker, a seasonal worker or an employee of an educational facility on a scheduled seasonal break;]
[[5.] are terminated as a result criminal misconduct as defined by local, state or federal law (including but not limited to use of illegal drugs);]
[[6.] are terminated as a result of willful misconduct meaning a transgression of some established rule of conduct, a forbidden act or a willful act of dishonesty or dereliction of duty;]
[[7.] are employed by a member of Your immediate family including but not limited to a spouse, parent, child or sibling;]
[[8.] become aware either orally or in writing of pending unemployment within 90 days prior to the Effective Date of Your coverage under the Policy;]
[[9.] are self-employed or an independent contractor;]
[[10.] become unemployed as a result of war, declared or undeclared, riot, insurrection, rebellion, or revolution;]
[[11.] become unemployed as a result of a discharge of pollutants or a nuclear occurrence;]
[[12.] have not been currently employed at a full time job and working at least thirty (30) hours per week for at least [6] consecutive [months] immediately prior to the date Your Family Leave begins;]
[[13.] are a sole proprietor, partner or a controlling stockholder in the business in which You are employed or are a dependent of a sole proprietor, partner or a controlling stockholder in the business in which You are employed;] [or]
[[14.] are currently receiving benefits for any other Loss under the Policy;]

Benefits are subject to all terms and conditions of the Policy/Certificate. This Rider does not waive, alter or extend any provisions or limitations of the Policy/Certificate except to the extent shown above.

This Rider takes effect with the Policy/Certificate to which it is attached.

[   ]

Secretary President

# American Modern Home Insurance Company
## Home Office: Amelia, Ohio
**[Administrative Office: 100 W. Bay Street, Jacksonville, FL 32202]**

## HOSPITALIZATION RIDER

This Hospitalization Rider is a part of the Policy/Certificate to which it is attached. It is issued in consideration of the application/enrollment form and the payment of the required premium.

**IMPORTANT NOTICE:** Benefits under this Hospitalization Rider are indemnity benefits payable directly to You. We have no contractual relationship to pay benefits to Your health care facilities or providers. Benefits under this Rider are independent of, and bear no relationship to, any health insurance You may have. Please be aware that Benefit amounts under this Rider have limits and may be less than Your outstanding obligations.

We will pay the Benefit Amount shown on the Schedule of Insurance if You file written Proof of Loss that You, while insured, were directed by a licensed medical doctor to be admitted to a hospital and you remained confined in the hospital overnight for at least three consecutive days as directed by the doctor.

The term “hospital” in the preceding paragraph includes any licensed medical hospital or chiropractic hospital, acute care, convalescent nursing, residential drug, psychiatric or hospice facility.

Payments will stop when We have paid benefits for the Maximum Benefit Period shown on the Schedule of Insurance.

**Exclusions:**

Benefits will not be paid for Hospitalization:
1. that begins while this Policy is not in force;
2. during either the Vesting Period or Elimination Period, if any;
3. if You are currently receiving benefits for any other Loss under this Policy;
4. for any Sickness, Injury or other condition of physical or mental health for which You were hospitalized or received medical or surgical treatment, including medication, consultation, advice or therapy within the [12] months preceding the Certificate Effective Date and which caused, or contributed to, Hospitalization within [12] months following the Certificate Effective Date;

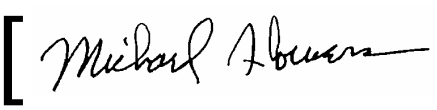
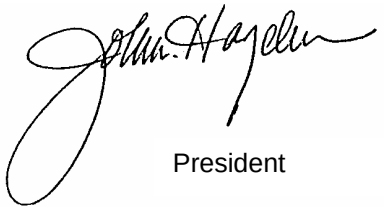
In addition, no benefit shall be paid for Hospitalization which is caused by, results from, or is contributed to by any of the following:

[[5.] intentional self-inflicted Injury, while sane or insane;]
[[6.] declared or undeclared war or any act of war;]
[[7.] the use or taking of any narcotic, medication or hallucinogen or any other drug by You unless taken or used as prescribed by a Physician;]
[[8.] alcohol intoxication, as defined in the state criminal or civil statutes, whichever is more restrictive or a blood alcohol level being .10 percent if not defined;]
[[9.] acting as a pilot or crew member or while a passenger other than a fare-paying passenger in any aircraft;]
[[10.] riding or driving in any kind of race for prize money or profit;]
[[11.] committing or attempting to commit a criminal act, an assault or felony;]
[[12.] taking of alcohol in combination with any drug, medication or sedative;]
[[13.] pregnancy or childbirth, including Caesarian Section]

Benefits are subject to all terms and conditions of the Policy/Certificate. This Rider does not waive, alter

or extend any provisions or limitations of the Policy/Certificate except to the extent shown above.

This Rider takes effect with the Policy/Certificate to which it is attached.

[   ]

Secretary President

# American Modern Home Insurance Company
## Home Office: Amelia, Ohio
**[Administrative Office: 100 W. Bay Street, Jacksonville, FL 32202]**

## JOINT COVERAGE RIDER

This Joint Coverage Rider is a part of the Policy/Certificate to which it is attached. It is issued in consideration of [the application/enrollment form and] the payment of the required premium.

For the purposes of this Rider, "Joint Coverage" means that the person named below is hereby added as an additional Covered Person to the Certificate. The Benefit Amounts listed on the Schedule of Insurance shall [be reduced by 50%] [be equal to the Benefit Amounts] per Covered Person per Coverage listed on the Schedule of Insurance. Otherwise, all references in the Policy/Certificate to the Covered Person, including pronouns, shall include the additional Covered Person, and all terms and conditions of the Policy/Certificate shall apply to both Covered Persons.

We will pay [50% of] the Benefit Amount shown on the Schedule of Insurance if either Covered Person files written Proof of Loss for a Coverage listed on the Schedule of Insurance, subject to all other eligibility requirements, dollar limits, time restrictions, conditions and exclusions in the Policy and Certificate of Insurance.

Joint Coverage must be elected at the time of enrollment or within [30] days of the Effective Date shown on the Schedule of Insurance.

Joint Coverage will terminate if a Covered Person becomes ineligible for Coverage pursuant to the Individual Termination of Coverage section of the Certificate of Insurance. Single Coverage will remain in force on the remaining eligible Covered Person until such time as provided in the Individual Termination of Coverage section of the Certificate of Insurance.

Benefits are subject to all terms and conditions of the Policy/Certificate. This Rider does not waive, alter or extend any provisions or limitations of the Policy/Certificate except to the extent shown above.

This Rider takes effect with the Policy/Certificate to which it is attached.

[ Secretary ] [ President ]

[By signing below, we acknowledge that we have read and understand the meaning of all disclosures and Notices on the [application][enrollment] form [and] [affirmatively elect to apply for [the Coverages listed [at 50% of the Benefit Amounts per Covered Person per Coverage listed, instead of at 100% of the Benefits for a single Covered Person per Coverage listed]].]

_____ _____/___/_____
[Printed Name of Additional Covered Person] Additional Covered Person's Date of Birth
(Must be between ages of 18 and [70])

_____
[Signature] Date

_____ CERTIFICATE NUMBER: [XXXXXXXX]
[Printed Name of Original Covered Person]

_____
[Signature] Date

# American Modern Home Insurance Company
## Home Office: Amelia, Ohio
**[Administrative Office: 100 W. Bay Street, Jacksonville, FL 32202]**

## MEDICAL WITHDRAWAL RIDER

This Medical Withdrawal Rider is a part of the Policy/Certificate to which it is attached. It is issued in consideration of the application/enrollment form and the payment of the required premium.

For the purposes of this Rider, "Medical Withdrawal" means the Covered Person withdraws as a student from a term of classes in which tuition has been paid at a university, college or trade school as a direct result of Injury or Sickness, and the tuition is not refunded to the Covered Person.

The Benefit Amount shown on the Schedule of Insurance is equal to the "Unreimbursed Portion of Tuition," which means 100% of the paid tuition and fees for the term of classes (including tuition paid through loans, grants or scholarships) less any refund or credit due the Covered Person from the educational institution.

We will pay the Benefit Amount shown on the Schedule of Insurance if You file written Proof of Loss that You have been granted a Medical Withdrawal while insured, documenting that Injury or Sickness forced You to completely withdraw from all classes for the balance of a term of classes, and Your Proof of Loss is supported by signed documentation from an official of Your educational institution and Your licensed medical doctor.

Payments will stop when We have paid benefits for the Maximum Benefit Period shown on the Schedule of Insurance.

**Exclusions:**

Benefits will not be paid for Medical Withdrawal:
1. that begins while the Policy is not in force;
2. during the Vesting Period or Elimination Period, if any;
3. for a term of classes in which You had already begun classes prior to applying for this coverage;
4. if You were not currently registered as a full-time student at Your university, college or trade school on the day immediately prior to the date Your Medical Withdrawal took place;
5. if You are currently receiving benefits for any other Loss under the Policy or Certificate;

[6. for any Sickness, Injury or other condition of physical or mental health for which You were hospitalized or received medical or surgical treatment, including medication, consultation, advice or therapy within the [6] months preceding the Certificate Effective Date and which caused, or contributed to, Your Medical Withdrawal within [6] months following the Certificate Effective Date;]

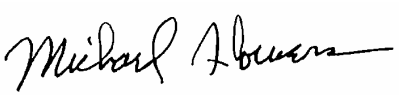
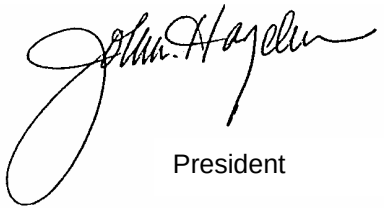
In addition, no benefit shall be paid for Medical Withdrawal which is caused by, results from, or is contributed to by any of the following:

[[6.] failure to attend classes for any reason other than Injury or Sickness;]
[[7.] intentional self-inflicted Injury, while sane or insane;]
[[8.] declared or undeclared war or any act of war, riot, insurrection, rebellion, terrorism or revolution;]
[[9.] the use or taking of any narcotic, medication or hallucinogen or any other drug by You unless taken or used as prescribed by a Physician;]
[[9.] alcohol intoxication, as defined in the state criminal or civil statutes, whichever is more restrictive or a blood alcohol level being .10 percent if not defined;]
[[10.] riding or driving in any kind of race for prize money or profit;]
[[11.] committing or attempting to commit a criminal act, an assault or felony;]
[[12.] taking of alcohol in combination with any drug, medication or sedative;]

[[13.] as a result of a discharge of pollutants or a nuclear occurrence;]
[[14.] pregnancy or childbirth, including Caesarian Section]

Benefits are subject to all terms and conditions of the Policy/Certificate. This Rider does not waive, alter or extend any provisions or limitations of the Policy/Certificate except to the extent shown above.

This Rider takes effect with the Policy/Certificate to which it is attached.

[   ]

Secretary President

# American Modern Home Insurance Company
## Home Office: Amelia, Ohio
**[Administrative Office: 100 W. Bay Street, Jacksonville, FL 32202]**

## ACCIDENTAL DEATH RIDER

This Accidental Death Rider is a part of the Policy/Certificate to which it is attached. It is issued in consideration of the application/enrollment form and the payment of the required premium.

Benefits are subject to all terms and conditions of the Policy and Certificate to which it is attached. This Rider does not waive, alter or extend any provisions or limitations of the Policy or Certificate except to the extent stated below.

### DEFINITIONS

When used in this Rider the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

**ACCIDENT** means specific unexpected, unforeseen events for which a time and place or occurrence can be identified which results in bodily Injury or Loss sustained by a Covered Person while this Rider is in force. Bodily Injury or Loss must be independent of disease or bodily infirmity.

**ACCIDENTAL DEATH** means death which results from Injury. The Accident causing such Injury must be specific to time and place and must occur after the Effective Date shown on the Schedule of Insurance and while this Policy is in force. Death must occur within [365 days] following the date of the Accident which caused the Injury.

**BENEFICIARY** means the person or entity named by the Covered Person and recorded in Our records.

**INJURY** means bodily injury caused by an Accident occurring while the insurance is in force resulting in a Loss:

1. directly and independently of all other causes; and
2. within [365 days] after the date of the Accident.

The Injury must not be caused by or contributed to by Sickness.

**LOSS** means loss of life.

**SICKNESS** means sickness or disease in which a Covered Person is diagnosed or treated for after the Effective Date and while this Certificate is in force.]

### BENEFITS

Benefits payable under this Rider are subject to all Policy provisions.

**ACCIDENTAL DEATH BENEFIT**: Upon receipt of Proof of Loss that a Covered Person dies, We will pay the Benefit Amount shown on the Schedule of Insurance provided:

(1) death occurs as a direct result of an Injury; and
(2) death occurs within [365 days] of the Accident causing the Injury.]

We may elect to pay the Maximum Aggregate Benefit Amount in one lump sum] [instead of in Monthly Benefit Amounts].] [A lump sum payment of the Maximum Aggregate Benefit Amount will fully discharge Our obligations to You for Accidental Death coverage under this Certificate.]]

**Exclusions:**

No benefit shall be paid for Loss which is caused by, results from, or is contributed to by any of the following:

[[1.] suicide or intentional self-inflicted injury, while sane or insane;]
[[2.] declared or undeclared war or any act of war;]
[[3.] the use or taking of any narcotic, medication or hallucinogen or any other drug by the Covered Person unless taken or used as prescribed by a Physician;]
[[4.] alcohol intoxication of the Covered Person, as defined in the state criminal or civil statutes, whichever is more restrictive or a blood alcohol level being .10 percent if not defined, where the Accident occurred;]
[[5.] the Covered Person acting as a pilot or crew member or while a passenger other than a fare-paying passenger in any aircraft;]
[[6.] riding or driving in any kind of race for prize money or profit;]
[[7.] committing or attempting to commit a criminal act, an assault or felony;]
[[8,] disease; sickness; bodily or mental infirmity; or medical or surgical treatment of these including diagnosis;]
[[9.] Injury that does not directly and independently of all other causes result in a Loss;]
[[10.] bacterial infection except through a wound accidentally sustained;]
[[11.] taking of alcohol in combination with any drug, medication or sedative;]

## CLAIMS PROVISIONS

**PROOF OF LOSS**. We must be given a certified copy of the death certificate as Proof of Loss of life. Proof of Loss must also include sufficient proof as We require to determine Our liability. Proof must be furnished no later than [one year] from the date of the Loss.

**PAYMENT OF CLAIMS**. All benefits for the Covered Person's Loss of Life will be paid in accordance with the Beneficiary designation in effect at the time of payment. All other benefits are paid directly to the Covered Person, unless otherwise specified. In the event of the Covered Person's death prior to benefits being paid, the payment will be made to the Beneficiary. If more than one Beneficiary is named without stating their respective interests, they will share equally. If a Beneficiary dies before the Covered Person, that interest ends. The Beneficiaries who survive will share equally unless the Covered Person makes a written request to the contrary. If no Beneficiary is named or survives the Covered Person, the benefit will be payable to the first surviving class of the following: the Covered Person's spouse, children, parents, brothers or sisters, or Covered Person's estate. If more than one Beneficiary in a class, they will share equally.

If a benefit is unpaid at the Covered Person's death or We determine he is not able to give a valid release for payment, We may pay an amount up to [$250] to any relative by blood or marriage who We deem to be equitably entitled. If a Beneficiary is a minor and there is no parent or legal guardian, or if he cannot give a valid release, the benefit will be paid as follows: to the person or institution We decide has assumed custody or support of the minor Beneficiary.

***[OR]***

[All Benefits are paid to the Designated Payee identified in the Claim Form for Proof of Loss. We will not be obligated to pay any amounts under this Policy to You, Your beneficiary or any other person, whether as loss payee, third party beneficiary, or other claimant, other than the confirmed Designated Payee.]

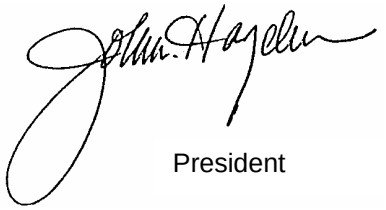
## GENERAL PROVISIONS

**CHANGE OF BENEFICIARY.** For benefits to be paid after the Covered Person's death, the Covered Person may designate or change a Beneficiary at any time by writing to Us. Once We record the change, it will take effect as of the day the request was signed. Any claim payment made before such recording is not subject to the change. The consent of the Beneficiary is not needed for the change unless the

Beneficiary designation was irrevocable.

**AUTOPSY.** At Our expense, We may have an autopsy done in case of death where it is not forbidden by law.

This Rider takes effect with the Policy/Certificate to which it is attached.

[   ]

Secretary President

[123 1234 1234 1234567890123456 12 J] [JOHN Q. SAMPLE, 1234 ANYSTREET, ANYTOWN ARKANSAS 12345-1234]

**[INVOLUNTARY UNEMPLOYMENT] INSURANCE**
**[APPLICATION] [ENROLLMENT FORM]**
**[Coverage] [Provided By:]** **AMERICAN MODERN HOME INSURANCE COMPANY**
**[100 W. Bay St., Jacksonville, FL 32202]**
**[Policyholder]**

[As part [a member] of [the group of] _____,] [[I am applying for] the insurance coverages checked below:]

| COVERAGES |
|---|
| [□] [Involuntary Unemployment] |
| [□] [Accidental Death Rider] |
| [□] [[Accidental] Disability Rider] |
| [□] [Family Leave Rider] |
| [□] [Hospitalization Rider] |
| [□] [Medical Withdrawal Rider] |
| [□] [Joint Coverage Rider] |

**[Benefits for each coverage are subject to the time periods and dollar limits shown in your Schedule of Insurance.]**

**[For coverages of [Accidental Death], [Disability], [Accidental Disability], [Family Leave], [Hospitalization], and/or [Medical Withdrawal ], Eligible Covered Persons shall be between ages [18 and 70], and benefits will be reduced by [50%] if Loss occurs after attaining age [60] and will expire by age [71].]**

**[If the Joint Coverage Rider is selected, Benefits may be reduced by 50% per Covered Person.]**

[DECLARED EXPENSE(S):]
[Benefit Amounts will be fixed based on the last billing period preceding the Loss]
[Designated Payee will be confirmed by the insurer in the Claim Form for Proof of Loss]
[Description/Account_____Account #_____] [Designated Payee_____]
[Description/Account_____Account #_____] [Designated Payee_____]
[Description/Account_____Account #_____] [Designated Payee_____]
[Description/Account_____Account #_____] [Designated Payee_____]

_____/___/_____
Covered Person's Date of Birth

_____
[Name of Beneficiary] [Date of Birth] [Relationship]

TOTAL MONTHLY PREMIUM: [$XXX.XX] [per $XXXX.XX] [of Monthly Benefit Amount]

**CHARGE AUTHORIZATION:** [I authorize the necessary [monthly] premiums to be [charged to/deducted from] my [Name of Account] for the coverage I elected.] [I authorize the monthly premium deducted from my [ABC Company] [checking/savings account].] [My [card/account] number is □□□□□□□□□□□□□□□□ [expiration date □□□□□□].] This authorization will continue until cancelled by my notification to the Administrative Office of the Insurers. [Charges/Deductions] will begin after the necessary processing has been completed. [I understand that the coverage I elect above will become effective and continue only upon payment of premiums as they become due.]

**[IMPORTANT DISCLOSURES:]**

**[[I understand that this insurance is optional.] [It is not required as part of my expense obligations listed above.]**

**[I understand that Benefit Amounts under this insurance are payable directly to me or to my beneficiary and may be**

**used to help pay my monthly expenses or for any other purpose. I understand that my insurer has no contractual obligation to make payments to my payees on my behalf. I understand that Benefit Amounts may have limits and may be less than my actual monthly expenses or outstanding balances. I understand that No Benefits will be paid until the [Vesting Period and] Elimination Period [have] [has] been satisfied.]**

***[OR]***

**[I understand that Benefit Amounts under this insurance are payable to my Designated Payees for the Declared Expense(s). I understand that my insurer has no contractual obligation to pay any amounts under this Policy to me, my beneficiary or any other person, whether as loss payee, third party beneficiary, or other claimant, other than the confirmed Designated Payees. I understand that Benefit Amounts may have limits and may be less than my actual monthly expenses for the Designated Payees. I understand that no Benefits will be paid until the [Vesting Period and] Elimination Period [have] [has] been satisfied.]**

**[I understand that for coverages of [Accidental Death], [Disability], [Accidental Disability], [Family Leave], [Hospitalization], and/or [Medical Withdrawal], this policy excludes any condition of physical or mental health for which I was hospitalized or received medical or surgical treatment, including medication, consultation, advice or therapy within the [12] months preceding my Certificate Effective Date and which causes, or contributes to, a loss within [12] months following the Certificate Effective Date.]**

**[I understand that this policy excludes coverage if I have not been currently employed at a full time job and working at least thirty (30) hours per week for at least [6] consecutive [months] immediately prior to the date my Involuntary Unemployment [or Disability] begins.]**

**[I understand that there are additional eligibility requirements, dollar limits, time restrictions, conditions and exclusions for each Coverage that could delay or even prevent payment of Benefits. I should read my Certificate of Insurance for a complete explanation of these eligibility requirements, time restrictions, conditions and exclusions.]**

**[I understand that this insurance is not a deposit or other obligation of, or guaranteed by, my creditors. This insurance coverage is not insured by the FDIC or any other agency of the United States or my creditors.]**

**[“SEE SPECIFIC STATE FRAUD NOTICES ON NEXT PAGE”]**

[By signing below, I acknowledge that I have read and understand the meaning of the above disclosures [and] [am applying for] [enrolling for] [the coverage as indicated above].] [By signing below, I hereby certify that all of the information I have provided on this form is true and correct.]

_____

[Printed Name]

_____

[Signature] Date

[The Covered Person who is an authorized user on the account above is the only person authorized to sign this form and must be between the ages of 18 and [70].]

## SPECIFIC STATE NOTICES

**Fraud Warning:**

If You reside in, or are applying for, insurance under a policy issued in one of the following states, please read the applicable warning.

**Alaska Residents:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arizona Residents:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas and New Mexico Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**California Residents:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Delaware and Idaho Residents:** Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of a claim containing any false, incomplete, or misleading information is guilty of a felony.

**District of Columbia Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Hawaii Residents:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Indiana Residents:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Louisiana Residents and any state not listed:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Tennessee and Virginia Residents**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

**Maine Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Minnesota Residents:** A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire Residents:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a

statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in R.S.A. §638:20.

**New Jersey Residents:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

**Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or application containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact may be guilty of an insurance fraud, which is a crime, and may be subject to prosecution.

**Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Texas and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

[123 1234 1234 1234567890123456 12 J] [JOHN Q. SAMPLE, 1234 ANYSTREET, ANYTOWN ARKANSAS 12345-1234]

**[[CHANGE][UPDATE] REQUEST FORM] [POLICYHOLDER]**
**[INVOLUNTARY UNEMPLOYMENT] INSURANCE AMERICAN MODERN HOME INSURANCE COMPANY]**
[Please complete this form if you would like to make changes to your Certificate].

[☐][I elect to [change][increase] my coverage or benefits as follows:]

[☐] [I elect to make changes to my Declared Expenses as follows:]

- **Any changes to original coverage or Declared Expenses will trigger a new Certificate Effective Date for purposes of Certificate Schedule Time Periods and coverage exclusions.**
- **Benefits for each coverage change are subject the time periods and dollar limits shown in your replacement Schedule of Insurance.**
- **[For coverages of [Accidental Death], [Disability], [Accidental Disability], [Family Leave], [Hospitalization], and/or [Medical Withdrawal ]: Eligible Covered Persons shall be between ages [18 and 70], and benefits will be reduced by [50%] if Loss occurs after attaining age [60] and will expire by age [71].]**
- **If the Joint Coverage Rider is selected, Benefits may be reduced by 50% per Covered Person.**

NEW TOTAL MONTHLY PREMIUM: [$XXX.XX] [per $XXXX.XX] [of Benefit Amount]

[☐] [I elect to change my Beneficiary to:]

_____

[Name of Beneficiary] [Date of Birth] [Relationship]

**CHARGE AUTHORIZATION:** [I authorize the necessary [monthly] premiums to be [charged to/deducted from] my [Name of Account] for the coverage I elected.] [I authorize the monthly premium deducted from my [ABC Company] [checking/savings account].] [My [card/account] number is □□□□□□□□□□□□□□□□ [expiration date □□□□□□].] This authorization will continue until cancelled by my notification to the Administrative Office of the Insurers. [Charges/Deductions] will begin after the necessary processing has been completed. [I understand that the coverage I elect above will become effective and continue only upon payment of premiums as they become due.]

**[IMPORTANT DISCLOSURES:]**

**[[I understand that this insurance is optional.] [It is not required as part of my expense obligations listed above.]**

**[I understand that Benefit Amounts under this insurance are payable directly to me or to my beneficiary and may be used to help pay my monthly expenses or for any other purpose. I understand that my insurer has no contractual obligation to make payments to my payees on my behalf. I understand that Benefit Amounts may have limits and may be less than my actual monthly expenses or outstanding balances. I understand that No Benefits will be paid until the [Vesting Period and] Elimination Period [have] [has] been satisfied.]**
***[OR]***
**[I understand that Benefit Amounts under this insurance are payable to my Designated Payees for the Declared Expense(s). I understand that my insurer has no contractual obligation to pay any amounts under this Policy to me, my beneficiary or any other person, whether as loss payee, third party beneficiary, or other claimant, other than the confirmed Designated Payees. I understand that Benefit Amounts may have limits and may be less than my actual monthly expenses for the Designated Payees. I understand that no Benefits will be paid until the**

**[Vesting Period and] Elimination Period [have] [has] been satisfied.]**

**[I understand that for coverages of [Accidental Death], [Disability], [Accidental Disability], [Family Leave], [Hospitalization], and/or [Medical Withdrawal], this policy excludes any condition of physical or mental health for which I was hospitalized or received medical or surgical treatment, including medication, consultation, advice or therapy within the [12] months preceding my Certificate Effective Date and which causes, or contributes to, a loss within [12] months following the Certificate Effective Date.]**

**[I understand that this policy excludes coverage if I have not been currently employed at a full time job and working at least thirty (30) hours per week for at least [6] consecutive [months] immediately prior to the date my Involuntary Unemployment [or Disability] begins.]**

**[I understand that there are additional eligibility requirements, dollar limits, time restrictions, conditions and exclusions for each Coverage that could delay or even prevent payment of Benefits. I should read my Certificate of Insurance for a complete explanation of these eligibility requirements, time restrictions, conditions and exclusions.]**

**[“SEE SPECIFIC STATE FRAUD NOTICES ON NEXT PAGE”]**

By signing below, I acknowledge that I have read and understand the meaning of the above disclosures [and] [affirmatively elect to[change][increase][purchase] the coverage as indicated above]. [By signing below, I hereby certify that all of the information I have provided on this form is true and correct.]

_____
[Printed Name]

_____
[Signature] Date

[The primary Covered Person who is an authorized user on the account above is the only person authorized to sign above and must be between the ages of 18 and [70].]

_____ _____/___/_____
[Printed Name of Additional Covered Person if Joint Coverage] Additional Covered Person’s Date of Birth
(Must be between ages of 18 and [70])

_____
[Signature] Date

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# American Modern Home Insurance Company
## Home Office: Amelia, Ohio
**[Administrative Office: 100 W. Bay Street, Jacksonville, FL 32202]**

**PLEASE READ YOUR CERTIFICATE CAREFULLY**

**RIGHT TO EXAMINE CERTIFICATE**

If You are not satisfied with this insurance after You receive it, You may return this Certificate within [30 days] to Our Administrative Office or to Our authorized agent. You will receive a full refund of any premium You have paid and this Certificate will be void from the beginning.

## CERTIFICATE OF INSURANCE

The Covered Person and Coverages are shown on the Schedule of Insurance. Place the Schedule of Insurance with this Certificate for safekeeping.

American Modern Home Insurance Company (herein called "We", "Us" or "Our") has issued the Group Policy (herein referred to as the "Policy") to the Group Policyholder shown on the Certificate Schedule of Insurance. This Certificate is subject to the terms of the Policy and the Policy is part of the contract between the Group Policyholder and Us. American Modern Home Insurance Company makes available Involuntary Unemployment Insurance for eligible persons.

We agree to pay the benefits described in this Certificate with respect to the Covered Person as shown on the Certificate Schedule of Insurance, subject to all terms of the Policy.

This Certificate supersedes any certificate previously issued to You under the Policy. You may qualify under only one Involuntary Unemployment Certificate under the Policy with Us. If any person is insured under more than one Certificate under the Policy, We will consider that person to be insured under the Certificate which provides the greatest amount of coverage. Upon discovery of the duplication, We will refund any duplicated premium payments which may have been made on behalf of that person. The records maintained by the Group Policyholder shall determine the insurance provided under the Policy for any Covered Person.

[ ]

Secretary President

**GROUP INVOLUNTARY UNEMPLOYMENT INSURANCE**

**CONTENTS**

## CERTIFICATE SCHEDULE OF INSURANCE

This Schedule of Insurance is part of Your Certificate. It is effective [ 10-01-2007 ] and supersedes any Schedule of Insurance issued under Group Policy No. [ 123456 ] bearing an earlier Effective Date.

GROUP POLICYHOLDER: [ ABC Group Policyholder Association ] CERTIFICATE NUMBER: [ 0006789 ]

EFFECTIVE DATE: [XX/XX/XXXX] (becomes effective at 12:01 A.M. at the Your address)
COVERED PERSON: [John Doe, 1234 Nowhere Street, Anytown, Arkansas 111111] **[Eligible Covered Persons shall be between ages [18 and 70]. For coverages of [Accidental Death], [Disability], [Accidental Disability], [Family Leave], [Hospitalization], and/or [Medical Withdrawal ], Eligible Covered Persons shall be between ages [18 and 70], and benefits will be reduced by [50%] if Loss occurs after attaining age [60] and will expire by age [71].]**

**[Benefit Amounts shown below are payable directly to You or to Your beneficiary and may be used to help make Declared Expense payments or for any other purpose. We have no contractual obligation to make payments to Your payees on Your behalf. Benefit Amounts may have limits and may be less than Your actual monthly expenses. You will not be eligible for Benefits until the [Vesting Period and] Elimination Period [have] [has] been satisfied.]**
***[OR]***
**[Benefit Amounts shown below are payable to the Designated Payee identified in the Claim Form for Proof of Loss. Prior to paying any Benefits, We will confirm that the Designated Payee identified by You is the payee for the Declared Expense(s). We will not be obligated to pay any amounts under this Policy to You, Your beneficiary or any other person, whether as loss payee, third party beneficiary, or other claimant, other than Your confirmed Designated Payee. Benefit Amounts may have limits and may be less than Your actual monthly expenses owed to the Designated Payee. No Benefits will be paid until the [Vesting Period and] Elimination Period [have] [has] been satisfied.]**

| COVERAGES | TIME PERIODS | MONTHLY BENEFIT AMOUNT | MAXIMUM MONTHLY BENEFIT AMOUNT | MAXIMUM AGGREGATE MONTHLY BENEFIT AMOUNT |
|---|---|---|---|---|
| [Involuntary Unemployment] | [[Noncontributory Period: [X] [days][months]]<br>[Vesting Period: [X] [days][months]]<br>[Elimination Period: [X] [days][months]]<br>[Maximum Benefit Period: [X] [days][months]]<br>[Requalification Period:[X] [days][months]]<br>[Maximum Coverage Period: [X] [days][months]] | [$XXXX.XX] [See Declared Expense(s) below] | [$XXXX.XX] | [$XXXX.XX] |
| [Accidental Death Rider] | [[Noncontributory Period: [X] [days][months]]<br>[Vesting Period: [X] [days][months]]<br>[Elimination Period: [X] [days][months]]<br>[Maximum Benefit Period: [X] [days][months]]<br>[Requalification Period:[X] [days][months]]<br>[Maximum Coverage Period: [X] [days][months]] | [$XXXX.XX] [See Declared Expense(s) below] | [$XXXX.XX] | [$XXXX.XX] |
| [[Accidental] Disability Rider] | [[Noncontributory Period: [X] [days][months]]<br>[Vesting Period: [X] [days][months]]<br>[Elimination Period: [X] [days][months]]<br>[Maximum Benefit Period: [X] [days][months]]<br>[Requalification Period:[X] [days][months]]<br>[Maximum Coverage Period: [X] [days][months]] | [$XXXX.XX] [See Declared Expense(s) below] | [$XXXX.XX] | [$XXXX.XX] |
| [Family Leave Rider] | [[[Noncontributory Period: [X] [days][months]]<br>[Vesting Period: [X] [days][months]]<br>[Elimination Period: [X] [days][months]]<br>[Maximum Benefit Period: [X] [days][months]]<br>[Requalification Period:[X] [days][months]]<br>[Maximum Coverage Period: [X] [days][months]] | [$XXXX.XX] [See Declared Expense(s) below] | [$XXXX.XX] | [$XXXX.XX] |

| | | | | |
|---|---|---|---|---|
| [Hospitalization Rider] | [[Noncontributory Period: [X] [days][months]]<br>[Vesting Period: [X] [days][months]]<br>[Elimination Period: [X] [days][months]]<br>[Maximum Benefit Period: [X] [days][months]]<br>[Requalification Period:[X] [days][months]]<br>[Maximum Coverage Period: [X] [days][months]] | [$XXXX.XX] [See Declared Expense(s) below] | [$XXXX.XX] | [$XXXX.XX] |
| [Medical Withdrawal Rider] | [[Noncontributory Period: [X] [days][months]]<br>[Vesting Period: [X] [days][months]]<br>[Elimination Period: [X] [days][months]]<br>[Maximum Benefit Period: [X] [days][months]]<br>[Requalification Period:[X] [days][months]]<br>[Maximum Coverage Period: [X] [days][months]] | [Unreimbursed Portion of Tuition] | [$XXXX.XX] | [$XXXX.XX] |
| [Joint Coverage Rider] | [Same as Above per Covered Person per Coverage]<br>[Same Time Periods as Above with 50% of the Amounts per Covered Person per Coverage above] | | | |

[DECLARED EXPENSE(S):]

[Benefit Amounts will be fixed based on the last billing period preceding the Loss]
[Designated Payee will be confirmed by the insurer in the Claim Form for Proof of Loss]
[Description/Account_____Account #_____] [Designated Payee_____]
[Description/Account_____Account #_____] [Designated Payee_____]
[Description/Account_____Account #_____] [Designated Payee_____]
[Description/Account_____Account #_____] [Designated Payee_____]

TOTAL MONTHLY PREMIUM: [$XXX.XX] [per $XXXX.XX] [of Monthly Benefit Amount] due on or before the _____ day of each month.

## DEFINITIONS

When used in this Certificate the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

**BENEFIT PERIOD** means the period of consecutive days of Loss for which a benefit is payable. Benefits will begin on the 1st day of the Loss after the [Vesting Period and] Elimination Period [have] [has] been satisfied. The Benefit Period will stop on the earliest of: 1) the date the You are no longer incurring the Loss; or 2) when benefits are paid for the Maximum Benefit Period shown on the Certificate Schedule of Insurance; or 3) when the Maximum Aggregate Benefit Amount has been paid as shown on the Certificate Schedule of Insurance. The same continuous Loss is not eligible for more than one Benefit Period.

**COVERED PERSON** (herein called "You," "Your" or "Yours") means You, the Covered Person named on the Certificate Schedule of Insurance.

**[DECLARED EXPENSE** means the monthly expense or expenses listed on the Certificate Schedule of Insurance which are used to determine the Monthly Benefit Amount.]

**[DESIGNATED PAYEE** means the payee for the Declared Expense(s) as provided by You in the Proof of Loss form for a given claim as confirmed by Us. The Designated Payee will serve as payee for Benefits on behalf of You. We will not be obligated to pay any amounts under this Policy to You, Your beneficiary or any other person, whether as loss payee, third party beneficiary, or other claimant, other than the confirmed Designated Payee.]

**[ELIMINATION PERIOD** means a period of consecutive [days/ months] of Loss for which no benefit is payable. The Elimination Period is shown on the Schedule of Insurance and begins on the first day of the Loss. Benefits are payable beginning on the first day after the Elimination Period is satisfied. [The Elimination Period will not begin until the Vesting Period has been satisfied and You are eligible for Benefits.]]

**EMPLOYMENT** means working full time for salary or wages at least [30 hours] per week.

**INVOLUNTARY UNEMPLOYMENT** means that You have totally and continuously lost Your full-time Employment as a result of:
(1) a permanent involuntary termination of employment; or
(2) an involuntary layoff or suspension of employment; or
(3) an authorized, unionized strike or labor dispute by a chartered or previously organized trade or labor union; or
(4) a lockout, discharge of employees or temporary closing of business in response to organized employee activity; or
(5) a state or federally declared disaster caused by a geological or weather-related natural event.

**LOSS** means an event of Involuntary Unemployment. [For additional Benefit Riders, Loss is defined as provided by those Riders.]

**[MAXIMUM AGGREGATE BENEFIT AMOUNT** means the dollar amount shown on the Certificate Schedule of Insurance under the "Maximum Aggregate Benefit Amount" Column per coverage. The sum of all Monthly Benefit Amounts paid under this Policy will not exceed the Maximum Aggregate Benefit Amount per coverage.]

**[MAXIMUM MONTHLY BENEFIT AMOUNT** means the dollar amount shown on the Certificate Schedule of Insurance under the "Maximum Monthly Benefit Amount" Column per coverage. The Monthly Benefit Amount will not exceed the Maximum Monthly Benefit Amount per month per coverage.]

**[MAXIMUM COVERAGE PERIOD** means the period of consecutive [days/months] during which a Covered Person is eligible to file a claim for Loss under this Policy. The Maximum Coverage Period begins on Your Certificate Effective Date. The Maximum Coverage Period ends on the last day of the [XX] month from the Certificate Effective Date. Benefits activated prior to the last day of the Maximum Coverage Period can continue until the Borrower's continuous Loss ceases, subject to the Maximum Monthly Benefit Amount and Maximum Benefit Period**.]**

[**MONTHLY BENEFIT AMOUNT** means [the dollar amount shown on the Certificate Schedule of Insurance under the "Monthly Benefit Amount" Column.] *[OR]* [the amount owed by You for the Declared Expense(s) listed on the Certificate Schedule of Insurance as of the last billing period preceding the date when the Loss begins.] The Monthly Benefit Amount, once determined for a given Loss, will remain constant throughout the Benefit Period for that Loss and may differ from Your actual monthly expenses. The Monthly Benefit Amount is payable to [You] *[OR*] [the Designated Payee(s)] in the event of a Loss for the applicable Benefit Period, subject to the eligibility requirements, dollar limits, time restrictions, conditions and exclusions contained in the Policy. [The Monthly Benefit Amount may not exceed the Maximum Monthly Benefit Amount per month or the Maximum Aggregate Benefit Amount per Covered Person shown on the Certificate Schedule of Insurance.]] [If eligible, You may elect to make changes to Your Coverages or Monthly Benefit levels by contacting Us; however, the date the changes go into effect will be considered a new Certificate Effective Date for purposes of applying waiting periods and exclusions.]

**[NONCONTRIBUTORY PERIOD** means a period of consecutive [days/months] from the Effective Date of this Certificate during which the Group Policyholder provides coverage to You [at no cost] [at a reduced cost] to You. The Noncontributory Period for each Coverage is shown on the Certificate Schedule of Insurance. After the Noncontributory Period, the Covered Person may elect to renew coverage or change coverage by contacting Us and completing a change request form; however, the date the renewal or changes go into effect will be considered a new Certificate Effective Date for purposes of applying waiting periods and coverage exclusions**.]**

**[REQUALIFICATION PERIOD** means a period of consecutive [days/months] which must elapse between the end of one Benefit Period and the beginning of another Benefit Period before You are eligible to file a new claim for Loss for the same type of coverage. The same continuous Loss is not eligible for more than one benefit period. The Requalification Period for each Coverage is shown on the Certificate Schedule of Insurance**.]**

**[VESTING PERIOD** means a period of consecutive [days/months] from the Effective Date of this Certificate during which You are not eligible to file a claim or receive Benefits even if a Loss occurs. The Vesting Period, if any, for each Coverage is shown on the Certificate Schedule of Insurance.]

**WE, US, AND OUR** means the insurer, American Modern Home Insurance Company.

## WHEN YOUR INSURANCE BEGINS

Your coverage will become effective on the Certificate Effective Date shown on the Schedule of Insurance.

## BENEFITS

Benefits payable under this Certificate are subject to all Policy provisions.

**INVOLUNTARY UNEMPLOYMENT BENEFIT:** We will pay a benefit if You file written Proof of Loss that You involuntarily lost Your full-time Employment while insured under this Certificate. [The Vesting Period must have been satisfied and] You must be unemployed for the number of days in the Elimination Period. Benefits will begin on the 1st day of Involuntary Unemployment after the Elimination Period has been satisfied. If, after the Elimination Period, Your Involuntary Unemployment includes a period of less than a full month, We will pay 1/30th of the monthly insurance benefit for each day of that period. You will periodically be required to give us written Proof of Loss of Your continuing Involuntary Unemployment.

You must register and be approved for Unemployment benefits with Your state unemployment office and actively seeking Employment through a recognized Employment agency starting no later than 30 days after You lose Your Employment. You must continue to remain registered with the state unemployment office to continue to be eligible for benefits.

Payments will stop when You are no longer Involuntarily Unemployed or when benenfits reach the maximum limits shown on the Schedule of Insurance, whichever comes first.

Following the end of any previous claim for Involuntary Unemployment benefits, You may file a new claim for Involuntary Unemployment benefits after You have been employed for wages or profit for at least [30 hours] per week for the duration of the Requalification Period shown on the Certificate Schedule of Insurance.

## EXCLUSIONS

No Benefits will be paid by Us under the Policy or this Certificate if You:

[[1.] are Involuntarily Unemployed during [the Vesting Period or] Elimination Period;]
[[2.] voluntarily quit, resign, retire or have an employment contract expire;]
[[3.] die or are on disability, on family leave or on sick leave due to an accident, sickness, childbirth or pregnancy;]
[[4.] are a temporary worker, a seasonal worker or an employee of an educational facility on a scheduled seasonal break;]
[[5.] are terminated as a result criminal misconduct as defined by local, state or federal law (including but not limited to use of illegal drugs);]
[[6.] are terminated as a result of willful misconduct meaning a transgression of some established rule of conduct, a forbidden act or a willful act of dishonesty or dereliction of duty;]
[[7.] are employed by a member of Your immediate family including but not limited to a spouse, parent, child or sibling;]
[[8.] become aware either orally or in writing of pending unemployment within 90 days prior to the Effective Date of this Certificate;]
[[9.] are self-employed or an independent contractor;]
[[10.] become unemployed as a result of war, declared or undeclared, riot, insurrection, rebellion, or revolution;]
[[11.] become unemployed as a result of a discharge of pollutants or a nuclear occurrence;]
[[12.] have not been currently employed at a full time job and working at least thirty (30) hours per week for at least [6] consecutive [months] immediately prior to the date Your Involuntary Unemployment begins;]
[[13.] are a sole proprietor, partner or a controlling stockholder in the business in which You are employed or are a dependent of a sole proprietor, partner or a controlling stockholder in the business in which You are employed;]
[[14.] are currently receiving benefits for any other Loss under the Policy or this Certificate;]

**[RENEWAL CONDITION**

Subject to the Individual Termination of Insurance Provisions below, You may keep this Certificate in force provided the Insurance is not in default for nonpayment of premium or has not been rescinded due to fraud or misrepresentation by You. We do not have the right to refuse a premium paid on or before the date due or within the Grace Period. Your coverage will expire if the premium is not paid by the end of the Grace Period.

You may cancel Your coverage upon written notice to Us.]

**INDIVIDUAL TERMINATION OF INSURANCE**

Your coverage under this Certificate automatically ends on the first of the following dates:

(1) The date this Policy is terminated; [or]

[(2) The date the Maximum Coverage Period ends or the Maximum Aggregate Benefit is reached for all coverages;] [or]

(3) The premium due date You [or Group Policyholder] fail to pay the required premium, except as provided in the Grace Period; [or]

[(4) The premium due date next following the date You cease to be included in the Group Policyholder's plan of insurance under this Policy;] [or]

[(5) The next monthly premium due date following attainment of age [71];][or]

[(6) The date You die (only applicable to that Covered Person)

Termination of the Policy will not prejudice any claim originating prior to termination subject to all other terms of the Policy.

**PREMIUMS**

**PAYMENT OF PREMIUM.** All premiums due by the terms of this Certificate shall be paid to Our Administrative Office on or prior to the day they are due. You are required to pay the premium shown on the Certificate Schedule of Insurance to keep this coverage in force.

**PREMIUM CHANGES.** We have the right to change the premium rates under the Policy by giving You and the Group Policyholder at least 30 days advance written notice. Premium rates may also change at any time You or the Group Policyholder make a coverage change request which We agree to accept.

**GRACE PERIOD.** If a premium is not paid when due, the insurance shall be in default. We will allow a [31 day] Grace Period to pay each premium after the first premium. If a premium is not paid at the end of the Grace Period, the insurance shall terminate as of the last date for which premiums were paid. When a Benefit is paid for a Loss incurred during the Grace Period, any premium due and unpaid may be deducted from the Benefit payment. Your Certificate will lapse if You do not pay Your premium before the end of the Grace Period.

**CLAIMS PROVISIONS**

**NOTICE OF CLAIM.** Written Notice of Claim must be given to Us within [30 days] after the date of Loss or as soon as possible but no later than [one year] from the date of Loss unless You are legally incapable of doing so. You may give the Notice or may have someone do it for You. The Notice should give Your name and Certificate number as shown on the Certificate Schedule of Insurance. Notice should be mailed to Our Administrative Office.

**CLAIM FORMS.** When We receive the claim notice, We will send the claimant forms for filing Proof of Loss. If We do not send the forms within 15 business days, the claimant can meet the Notice of Claim requirements by giving Us a written statement of what happened. We must receive this statement within the time given for filing Proof of Loss.

**PROOF OF LOSS**. For Involuntary Termination or Layoff, satisfactory written evidence that You have registered for work with Your state employment office or a recognized employment agency within [30 days] after the last day employed and remain registered and actively seeking new employment while Benefits are activated. For a Strike or Lockout, satisfactory evidence of involuntary unemployment, which may include a statement signed by a union officer is required. You must give satisfactory written proof of continuing Involuntary Unemployment on a monthly basis or any time upon Our request.

**TIME OF PAYMENT OF CLAIMS**. If it is determined benefits are payable, We Will pay all benefits covered by this Policy after We receive Proof of Loss satisfactory to Us.

**PAYMENT OF CLAIMS**. Benefits provided by the Policy will be paid after satisfactory Proof of Loss is received and We have determined We are liable.

All benefits are paid directly to You, unless otherwise specified. If You die, the benefit will be payable to Your estate.
***[OR]***
[All Benefits are paid to the Designated Payee identified in the Claim Form for Proof of Loss. We will not be obligated to pay any amounts under this Policy to You, Your beneficiary or any other person, whether as loss payee, third party beneficiary, or other claimant, other than the confirmed Designated Payee.]

**GENERAL PROVISIONS**

**CONFORMITY TO LAW**. Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which it is issued is amended to conform to the laws of that state.

**ENTIRE CONTRACT.** The Policy, [together with] [the Group Policyholder Application,] [the Certificate,][and any other attachments] [including any Riders], make up the entire contract of Insurance. The Policy may be changed by written agreement between the Policyholder and Us. Only Our Officer may waive or otherwise change any provision of the Policy or our rights thereunder, and no action, statement or agreement by any person or persons other than Our Officer in writing shall in any way bind or estop Us from enforcing the provisions of the Policy or Our rights thereunder. No agreement in conflict with, modifying or extending the Policy shall be valid unless in writing signed by Our Officer and made part of the Policy.

**MISSTATEMENT OF AGE.** If, as a result of misstatement of age by You, We accept a premium for any period when coverage would not normally have been in effect, then Our liability for such period shall be limited to a refund of all premiums paid for such period.

**MISREPRESENTATION, FRAUD AND OUR RIGHT TO RESCIND.** If We determine that You have concealed or misrepresented Your health, or any material fact in the application or proof of loss, attempted fraud, or false swearing and the coverage was issued or benefits paid in reliance upon those statements, We will deny the claim and, if applicable, rescind coverage. Our liability will be limited to the return of premiums, less benefits paid for such coverage.

**RIGHT OF RECOVERY.** If payments for claims exceed the maximum amount payable under any coverage provisions [or riders] of this Certificate, We have the right to recover the excess of such payments.

**LEGAL ACTIONS.** No action can be brought to recover on the Policy for at least [60 days] after written Proof of Loss has been furnished. No such action shall be brought more than [3 years] after the date Proof of Loss is required. If a time limit of this Certificate is less than allowed by the laws of the state where You live, the limit is extended to meet the minimum time allowed by such law.

**INCOME TAXATION.** Any benefits paid do not include provision for income tax owed by You or Your estate. You should consult Your own tax advisors regarding the tax consequences of any benefits received under the Policy.

# American Modern Home Insurance Company

**Home Office: Amelia, Ohio**
**[Administrative Office: 100 W. Bay Street, Jacksonville, FL 32202]**

## [ACCIDENTAL] DISABILITY RIDER

This [Accidental] Disability Rider is a part of the Policy/Certificate to which it is attached. It is issued in consideration of the application/enrollment form and the payment of the required premium.

Benefits are subject to all terms and conditions of the Policy and Certificate to which it is attached. This Rider does not waive, alter or extend any provisions or limitations of the Policy or Certificate except to the extent stated below.

### DEFINITIONS

When used in this Rider the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

**ACCIDENT** means specific unexpected, unforeseen events for which a time and place or occurrence can be identified which results in bodily Injury or Loss sustained by a Covered Person while this Rider is in force. Bodily Injury or Loss must be independent of disease or bodily infirmity.

**INJURY** means bodily injury caused by an Accident occurring while the insurance is in force resulting in a Loss:

1. directly and independently of all other causes; and
2. within [365 days] after the date of the Accident.

The Injury must not be caused by or contributed to by Sickness.

**LOSS** means Total Disability.

**[SICKNESS** means sickness or disease of the Covered Person which is diagnosed or treated after the Effective Date and while this Certificate is in force.]

**TOTAL DISABILITY** means, as the result of an Injury [or Sickness], the inability of the Covered Person to perform the material and substantial duties of any occupation for which they are reasonably fitted by education, training or experience.

### BENEFITS

Benefits payable under this Rider are subject to all Policy provisions.

**[ACCIDENTAL] DISABILITY BENEFIT:** We will pay the Benefit Amount shown on the Schedule of Insurance if the Covered Person files written Proof of Loss that he became Totally Disabled as the result of an Injury [or due to Sickness] while insured and that the Vesting Period, if any, is satisfied and the Total Disability exceeds the Elimination Period shown on the Schedule of Insurance. Benefits will begin on the 1st day of Total Disability after the Vesting Period and Elimination Period, if any, have been satisfied. If after the Elimination Period has been satisfied, the Covered Person's Total Disability includes a period of less than a full month, We will pay 1/30th of the monthly Benefit Amount for each day of Total Disability. The Covered Person will periodically be required to give Us written proof of the continuing Total Disability.

Payments will stop on the earliest of: 1) the date the Covered Person is no longer Totally Disabled; or 2) when Benefits reach the maximum limits shown on the Schedule of Insurance. The same continuous Loss is not eligible for more than one Benefit Period.

Following the end of any previous claim for [Accidental] Disability benefits, the Covered Person may file a new claim for benefits after he has been employed for wages or profit for at least [30 hours] per week for the duration of the Requalification Period shown on the Schedule of Insurance.

**Exclusions:**

Benefits will not be paid for Total Disability:

1. that begins while this Policy is not in force;
2. during the Vesting Period, if any, or Elimination Period;
3. if the Covered Person is currently receiving benefits for any other Loss under this Policy;
4. for any Sickness, Injury or other condition of physical or mental health for which the Covered Person was hospitalized or received medical or surgical treatment, including medication, consultation, advice or therapy within the [12] months preceding the Policy Effective Date and which caused, or contributed to, Total Disability within [12] months following the Policy Effective Date;
5. if the Covered Person has not been currently employed at a full time job and working at least [thirty (30)] hours per week for at least [6] consecutive [months] immediately prior to the date the Total Disability begins

In addition, no benefit shall be paid for Loss which is caused by, results from, or is contributed to by any of the following:

[[6.] intentional self-inflicted Injury, while sane or insane;]
[[7.] declared or undeclared war or any act of war;]
[[8.] the use or taking of any narcotic, medication or hallucinogen or any other drug by the Covered Person unless taken or used as prescribed by a Physician;]
[[9.] alcohol intoxication of the Covered Person, as defined in the state criminal or civil statutes, whichever is more restrictive or a blood alcohol level being .10 percent if not defined, where the Accident occurred;]
[[10.] the Covered Person acting as a pilot or crew member or while a passenger other than a fare-paying passenger in any aircraft;]
[[11.] riding or driving in any kind of race for prize money or profit;]
[[12.] committing or attempting to commit a criminal act, an assault or felony;]
[[13.] disease; sickness; bodily or mental infirmity; or medical or surgical treatment of these including diagnosis.]
[[14.] Injury that does not directly and independently of all other causes result in a Loss;]
[[15.] bacterial infection except through a wound accidentally sustained;]
[[16.] taking of alcohol in combination with any drug, medication or sedative;]
[[17.] pregnancy or childbirth, including Caesarian Section]

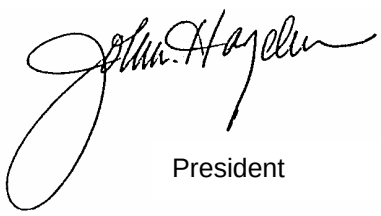
## CLAIMS PROVISIONS

**PROOF OF LOSS**. Written Proof of Loss signed by the Covered Person's Physician must be given to Us within [90 days] after the date of Loss or as soon as possible. Proof of Loss must also include sufficient proof as We require to determine Our liability. Proof must be furnished no later than [one year] from the time it is otherwise required, unless the Covered Person is legally incapable of doing so. The Covered Person may be required to be examined by a doctor chosen by Us, and in the event of conflicting opinions, the opinion of the doctor chosen by Us will be conclusive. Upon Our request, the Covered Person must provide written authorizations to allow the Covered Person's treating physician(s) or medical providers to discuss his Disability or to obtain relevant medical records. The Covered Person must give satisfactory written proof of his continuing Disability on a monthly basis or any time upon Our request.

## GENERAL PROVISIONS

**PHYSICAL EXAM.** At Our expense, We have the right to examine the Covered Person when and as often as is reasonable while a claim is pending.

This Rider takes effect with the Policy/Certificate to which it is attached.

[   ]

Secretary President

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-125388894* | *State:* | *Arkansas* |
| *Filing Company:* | *American Modern Home Insurance Company* | *State Tracking Number:* | *50* |
| *Company Tracking Number:* | *AMH-7000 (08-07)* | | |
| *TOI:* | *33.0 Other Lines of Business* | *Sub-TOI:* | *33.0001 Other Personal Lines* |
| *Product Name:* | *American Modern Home Insurance Company* | | |
| *Project Name/Number:* | *AMHI-7000/AMHI-7000 (08-07)* | | |

# Rate Information

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-125388894* | *State:* | *Arkansas* |
| *Filing Company:* | *American Modern Home Insurance Company* | *State Tracking Number:* | *50* |
| *Company Tracking Number:* | *AMH-7000 (08-07)* | | |
| *TOI:* | *33.0 Other Lines of Business* | *Sub-TOI:* | *33.0001 Other Personal Lines* |
| *Product Name:* | *American Modern Home Insurance Company* | | |
| *Project Name/Number:* | *AMHI-7000/AMHI-7000 (08-07)* | | |

# Supporting Document Schedules

**Review Status:**

**Satisfied -Name:** Uniform Transmittal Document-Property & Casualty 12/14/2007

**Comments:**

**Attachment:**

AMH industry_rates_pc_trans.pdf

**Review Status:**

**Satisfied -Name:** AMHI Authorization Letter 12/14/2007

**Comments:**

**Attachment:**

AMHI authorization ltr.pdf

**Review Status:**

**Satisfied -Name:** Cover letter 12/14/2007

**Comments:**

**Attachment:**

AR AMHI 7000 Letter 12-14-07.pdf

**Review Status:**

**Satisfied -Name:** Readability Certification 12/14/2007

**Comments:**

**Attachment:**

AMHI READ.pdf

**Review Status:**

**Satisfied -Name:** Fee schedule 12/14/2007

**Comments:**

**Attachment:**

AMHI AR_Fee_Schedule.pdf

**Review Status:**

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-125388894* | *State:* | *Arkansas* |
| *Filing Company:* | *American Modern Home Insurance Company* | *State Tracking Number:* | *50* |
| *Company Tracking Number:* | *AMH-7000 (08-07)* | | |
| *TOI:* | *33.0 Other Lines of Business* | *Sub-TOI:* | *33.0001 Other Personal Lines* |
| *Product Name:* | *American Modern Home Insurance Company* | | |
| *Project Name/Number:* | *AMHI-7000/AMHI-7000 (08-07)* | | |

**Satisfied -Name:** Certification of Compliance 12/14/2007

**Comments:**

**Attachment:**

AMHI Cert of Comp.pdf

Effective January 1, 2006

**Property & Casualty Transmittal Document (Revised 1/1/06)**

| 1. Reserved for Insurance Dept. Use Only | 2. Insurance Department Use only | |
|---|---|---|
| | a. Date the filing is received: | |
| | b. Analyst: | |
| | c. Disposition: | |
| | d. Date of disposition of the filing: | |
| | e. Effective date of filing: | |
| | New Business | |
| | Renewal Business | |
| | f. State Filing #: | |
| | g. SERFF Filing #: | |
| | h. Subject Codes | |

| 3. | **Group Name** American Modern Home Insurance Company | **Group NAIC #** 0127 |
|---|---|---|

| 4. | **Company Name(s)** | **Domicile** | **NAIC #** | **FEIN #** |
|---|---|---|---|---|
| | American Modern Home Insurance Company | Ohio | 23469 | 31-0715697 |
| | | | | |
| | | | | |
| | | | | |

| 5. | **Company Tracking Number** | AMH-7000-25 |
|---|---|---|

**Contact Info of Filer(s) or Corporate Officer(s)** [include toll-free number]

| 6. | Name and address | Title | Telephone #s | FAX # | e-mail |
|---|---|---|---|---|---|
| | Brenda Dawson<br>Insurance Compliance Consultants, Inc.<br>519 Colman Center Drive<br>Rockford, IL 61108 | Authorized Representative | 815-316-6714 | 815-316-6720 | brendadawson@inscompliance.com |
| | | | | | |

| 7. | Signature of authorized filer |  |
|---|---|---|
| 8. | Please print name of authorized filer | Brenda Dawson |

**Filing information** (see General Instructions for descriptions of these fields)

| 9. | **Type of Insurance (TOI)** | 33.0000 |
|---|---|---|
| 10. | **Sub-Type of Insurance (Sub-TOI)** | 33.0001 |
| 11. | **State Specific Product code(s)(if applicable)[See State Specific Requirements]** | N/A |
| 12. | **Company Program Title (**Marketing title) | Group Involuntary Unemployment Insurance |
| 13. | **Filing Type** | [ ] Rate/Loss Cost [ ] Rules [ ] Rates/Rules<br>[ **X** ] Forms [ ] Combination Rates/Rules/Forms<br>[ ] Withdrawal[ ] Other (give description) |
| 14. | **Effective Date(s) Requested** | New: Upon approval Renewal: |
| 15. | **Reference Filing?** | [ ] Yes [ X ] No |
| 16. | **Reference Organization (**if applicable) | N/A |
| 17. | **Reference Organization # & Title** | N/A |
| 18. | **Company's Date of Filing** | December 14, 2007 |
| 19. | **Status of filing in domicile** | [ ] Not Filed [ **X** ] Pending [ ] Authorized [ ] Disapproved |

**Property & Casualty Transmittal Document—**

| | | |
|---|---|---|
| **20.** | **This filing transmittal is part of Company Tracking #** | AMH-7000-25 |
| **21.** | **Filing Description** [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]<br><br>See attached cover letter | |

| | |
|---|---|
| **22.** | **Filing Fees** (Filer must provide check # and fee amount if applicable) N/A<br>[If a state requires you to show how you calculated your filing fees, place that calculation below] |

**Check #: EFT**
**Amount: $50**

**Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.**

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

Effective January 1, 2006

**FORM FILING SCHEDULE**

(This form must be provided ONLY when making a filing that includes forms)

**(Do not refer to the body of the filing for the forms listing, unless allowed by state.)**

| | | |
|---|---|---|
| **1.** | **This filing transmittal is part of Company Tracking #** | **AMH-7000-25** |

| | | |
|---|---|---|
| **2.** | **This filing corresponds to rate/rule filing number**<br>(Company tracking number of rate/rule filing, if applicable) | **N/A** |

| **3.** | **Form Name /Description/Synopsis** | **Form # Include edition date** | **Replacement Or withdrawn?** | **If replacement, give form # it replaces** | **Previous state filing number,** if required by stat |
|---|---|---|---|---|---|
| 01 | Group Policy Application | AMH-7000-15 (08-07) | [**X**] New<br>[ ] Replacement<br>[ ] Withdrawn | | |
| 02 | Group Policy | AMH-7000-25 (08-07) | [**X**] New<br>[ ] Replacement<br>[ ] Withdrawn | | |
| 03 | Certificate of Insurance | AMH-7000-35 (08-07) | [**X**] New<br>[ ] Replacement<br>[ ] Withdrawn | | |
| 04 | Enrollment Application | AMH-7000-40 (08-07) | [**X**] New<br>[ ] Replacement<br>[ ] Withdrawn | | |
| 05 | Change Request Form | AMH-7000-50 (08-07) | [**X**] New<br>[ ] Replacement<br>[ ] Withdrawn | | |
| 06 | Family Leave Rider | AMH-7000-51 (08-07) | [**X**] New<br>[ ] Replacement<br>[ ] Withdrawn | | |
| 07 | Hospitalization Rider | AMH-7000-52 (08-07) | [**X**] New<br>[ ] Replacement<br>[ ] Withdrawn | | |
| 08 | Joint Coverage Rider | AMH-7000-54 (08-07) | [**X** ] New<br>[ ] Replacement<br>[ ] Withdrawn | | |
| 09 | Medical Withdrawal Rider | AMH-7000-55 (08-07) | [**X** ] New<br>[ ] Replacement<br>[ ] Withdrawn | | |
| 10 | Accidental Death Rider | AMH-7000-70 (08-07) | [**X** ] New<br>[ ] Replacement<br>[ ] Withdrawn | | |
| 11 | Accidental Disability Rider | AMH-7000-80 (08-07) | [**X** ] New<br>[ ] Replacement<br>[ ] Withdrawn | | |

AMERICAN MODERN HOME INSURANCE COMPANY
7000 Midland Boulevard • Amelia, OH 45102
800.759.9008 • www.amig.com

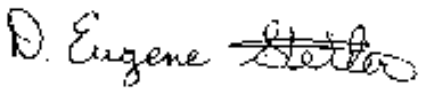
December 11, 2007

Brian Camling, President
Insurance Compliance Consultants, Inc.
519 Colman Center Drive
Rockford, IL 61108

Dear Mr. Camling:

Please accept this letter as written confirmation that Insurance Compliance Consultants, Inc., has authority to file the attached form(s) or a state specific variation of it, and to act on behalf of American Modern Home Insurance Company regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. American Modern Home Insurance Company may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,



D. Eugene Stetler
Senior Vice President

gstetler@amig.com
direct: 513-947-6738
fax: 513-947-4755

INSURANCE
COMPLIANCE
CONSULTANTS, INC.

519 Colman Center Drive
Rockford, Illinois 61108

Phone: (815) 316-6714
FAX: (815) 316-6720

December 14, 2007

Honorable Julie Benafield-Bowman
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: **AMERICAN MODERN HOME INSURANCE COMPANY**
NAIC# 23469 FEIN 31-0715697
Group Involuntary Unemployment Insurance Policy (Non-credit) - AMH-7000-25 (08-07)
Group Involuntary Unemployment Insurance Certificate – AMH-7000-35 (08-07)
Group Policy Application – AMH-7000-15 (08-07)
Enrollment Application Form – AMH-7000-40 (08-07)
Change Form – AMH-7000-50 (08-07)
Family Leave Rider – AMH-7000-51 (08-07)
Hospitalization Rider – AMH-7000-52 (08-07)
Joint Coverage Rider – AMH-7000-54 (08-07)
Medical Withdrawal Rider – AMH-7000-55 (08-07)
Accidental Death Rider – AMH-7000-70 (08-07)
Accidental Disability Rider – AMH-7000-80 (08-07)

Dear Commissioner Benafield-Bowman:

The following forms are submitted in duplicate for your review and approval. These forms are new and do not replace any forms previously approved by your department:

Insurance Compliance Consultants, Inc., is making this filing on behalf of American Modern Home Insurance Company. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc., at the address shown above.

This program is designed as a group indemnity program that provides Involuntary Unemployment benefits in the base product. Benefit amounts are determined by adding together certain typical monthly household budget expenses of the insured, subject to a maximum benefit amount and maximum number of months. The base benefits can be marketed together or individually. In addition, there are optional Benefit Riders that may be used in any combination for various marketing solicitations. In some instances, the product may be provided as non-contributory if so desired by the group policyholder.

Group Policy Application AMH-7000-15 (08-07) will be used to apply for Group Policy AMH-7000-25 (08-07). Group Policy AMH-7000-25 (08-07) will be issued to a group located outside of your state. Group Certificate AMH-7000-35 (08-07) will be issued to residents in your state.

These forms will be marketed through the following channels of distribution: direct mall, point of sale, telemarketing, internet or other methods of distribution. The enclosed Enrollment/Application Form can be used in each channel of distribution.

Text in brackets indicates the information that may be included or excluded depending upon the marketing approach. The amounts in brackets are representational. Please be assured that all bracketed areas will meet or exceed the requirements under applicable state and federal insurance law.

The format of the enclosed forms may vary depending on marketing and client needs, e.g. paper size, electronic distribution, etc. We reserve the right to reformat as is needed and to incorporate any additional future approved riders or amendatory endorsements; however, please be assured that the forms will meet or exceed the readability requirements and standards of applicable state law.

Your prompt approval of this filing would be greatly appreciated. If I can provide any additional information, please feel free to call me at (815)316-6714, fax me at (815) 316-6720, or e-mail me at Brendadawson@inscompliance.com . Thank you.

Sincerely,

Brenda Dawson, FLMI, AIRC, ACS
Authorized Representative
Insurance Compliance Consultants, Inc.

## FLESCH READING EASE TEST CERTIFICATION

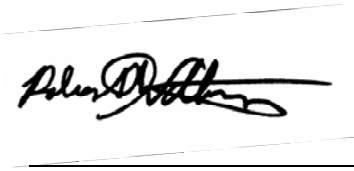
This is to certify that the forms listed below are in compliance with readability requirements of the Flesch Reading Ease Test, and the requirements of your state.

The Flesch Test was applied to the forms in their entirety, except that company name and address, form numbers, titles, captions, subcaptions, schedules, tables, defined words, and text required by law or regulation were excluded.

The Flesch Reading Ease scores are as follows:

| FORM NUMBERS | FLESCH SCORE |
|---|---|
| AMH-7000-25, et al | 51.08 combined |

**AMERICAN MODERN HOME INSURANCE COMPANY**



December 14, 2007

Date

Signature of Officer

Robert T. Watterson, Vice President and General Counsel

Name & Title of signer

**ARKANSAS**
INSURANCE
DEPARTMENT
1200 West Third Street
Little Rock Arkansas 72201-1904
501-371-2600

Mike Pickens
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: **American Modern Home Insurance Company**
Company NAIC Code: **23469**
Company Contact Person & Telephone # **Brenda Dawson, Insurance Compliance Consultants, Inc., (815) 316-6714**
Form Number(s): **AMH-7000-25 (08-07), et al.**

**********
* INSURANCE DEPARTMENT USE ONLY *
* *
* ANALYST:_____ AMOUNT:_____ ROUTE SLIP:_____ *
**********

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

| | | |
|---|---|---|
| Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing | *1 x $50 = $50<br>**Retaliatory _____ | |
| Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer. | * x $50 = _____<br>**Retaliatory _____ | |
| Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form. | * x $20 = _____<br>**Retaliatory _____ | |
| Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms. | * x $20 = _____<br>**Retaliatory _____ | |
| Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer. | * x $25 = _____<br>**Retaliatory _____ | |

AMEND CERTIFICATE OF AUTHORITY

| | | | |
|---|---|---|---|
| Review and processing of information to amend an Insurer's Certificate of Authority. | * | x $400 = | |
| Filing to amend Certificate of Authority. | *** | x $100 = | |

*THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.

**THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.

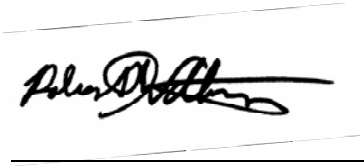
***THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. 23-61-401.

**Certificate of Compliance with**
**Arkansas Rule and Regulation 19**

Insurer: American Modern Home Insurance Company

Form Number(s): AMH-7000-25 (08-07), et al

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.



Signature of Company Officer

Robert T. Watterson
Name

Vice President and General Counsel
Title

December 14, 2007
Date